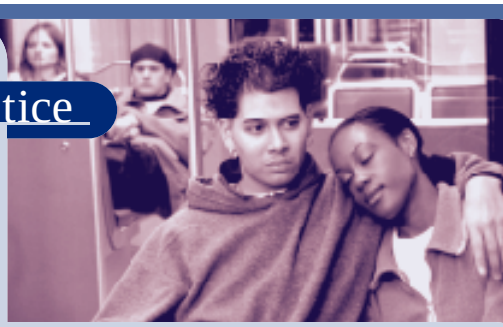
in Touch

HRSA Health Resources & Services Administration

SEPTEMBER 1998

BUREAU OF PRIMARY HEALTH CARE *The People We Serve...The People We Are*

Bring Teens into Your Practice



Teens come in all shapes and sizes. Some can put away a half gallon of ice cream at a sitting and never gain weight. Others run two miles without thinking about it, but sleep through morning classes. And many think that corn chips are vegetables. Yet the majority are healthy people who don't need medical attention, right? Wrong.

"I think teenagers are a neglected medical population," says Gina Paul, PA and NHSC loan repayment recipient at the Grandview Site of the Yakima Valley Farm Workers Clinic in Washington. "As a whole, they are a fairly healthy population, but they have so many more risks, and those risks have life-threatening or life-changing consequences."

Indeed, according to the Centers for Disease Control and Prevention, most health risks for adolescents are caused by behavior. Car crashes account for 30 percent of the deaths of youths between the ages of 5 and 24. Homicide and suicide respectively account for another 18 and 12 percent of the deaths.

Other negative behaviors often follow the teens to adulthood. It is common for teens to experiment with tobacco, drug and alcohol use, and risky sexual activity during those years between childhood illnesses and heart disease.

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Natural Disasters

Flood water rushed across the roads connecting Sierra City with Downieville, CA. The Downieville clinic remained dry, but people in Sierra City needed medical attention. So Frank Lang, NP and NHSC alum, took the only possible transportation, a helicopter. Flying into Sierra City, he set up a makeshift clinic where he would see patients for the duration of the 1997 flood.

Natural disasters don't differentiate between a house and a clinic, a business and a park. The challenge for NHSC clinicians is to keep providing excellent care when a disaster makes the clinic inaccessible or generates an overflow of patients. While not every disaster requires a helicopter ride, an emergency shipment of medications, or a new generator, each of these clinicians has been forced to think about how to manage a disaster. And with that planning, they managed to keep health care coming even as nature did its worst.

California Floods

After a few weeks of rain in January, the floods were predictable, says Lang, who was named an NHSC Clinician of the Year in 1998. The Sierras had had

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INSIDE

National Health Service Corps

The National Health Service Corps is a program of the Federal Health Resources and Services Administration's Bureau of Primary Health Care, which is the focal point for providing primary health care to underserved and vulnerable populations.

Achieving Cultural Competence

"Providing care is more complicated when you have a patient who is multicultural," says Sharon Barrett, head of the Office of Minority and Women's Health at the Bureau of Primary Health Care, in an article that appears in the Spring 1998 edition of the Journal of Minority Medical Students. "There are nuances to be aware of, and there is little documented information to help to understand them," she continues.

Providing culturally competent care has long been a focus of NHSC clinicians, but the growing diversity of the U.S. population is putting the issue on the front burner. According to Census Bureau projections, 42 million more people will be born in or immigrate to this country by the year 2000. Of that number, more than 75 percent will be members of various ethnic groups, primarily Asians, Hispanics and African Americans. Responding to the health care needs of this diverse population presents a challenge not only to the primary care clinicians serving in the NHSC, but also to clinicians everywhere.

NHSC's Chief Medical Officer, Rick Niska, MD, recognizes the importance of this issue. In an interview with In Touch, he said, "Cultural diversity is a challenge, because it destroys all our comfortable stereotypes."

The road to cultural competence has no shortcuts. To avoid potentially life-threatening misunderstandings that can arise from cultural differences between provider and patient, clinicians must work with each patient to understand his or her values, attitudes and behaviors.

Maria Garcia, an NHSC recruiter and coordinator in Seattle, WA, was interviewed by In Touch several years ago, but what she had to say about multiculturalism and cultural competence is even more relevant today. "Cultural competency is an evolutionary process. It is a "marathon, not a sprint," she said.

Garcia urged clinicians to take a close look at their own culture and beliefs to better understand how their perspective enhances or impedes cross-cultural communication. To eliminate barriers between patient and provider, Garcia recommended that clinicians take into account such factors as appropriate greetings and touching practices; folk medicine and religious beliefs and practices; views on health, illness, sexuality and death; language preference and interpretations needs; and literacy.

Only by understanding how the unique perspective of each patient is shaped by race, ethnicity, socioeconomic status and family background, can NHSC clinicians make real progress in eliminating health disparities and increasing access to quality health care.

To learn more about how to provide high-quality care to patients from diverse backgrounds, get in touch with the following resources:

- Office of Minority and Women's Health, Bureau of Primary Health Care, 4305 East West Highway, 3rd Floor, Bethesda, MD 20814, 301-594-4490
- Office of Minority Health Resources, Public Health Service, ***www.omhrc.gov***
- Resources for Cross Cultural Health Care, ***www.diversityrx.org*** ■

Recommendations for Providing Culturally Competent Care

An article on caring for refugees in a recent issue of American Family Physician (Vol. 57, No. 6) contains suggestions that can help all clinicians deal with patients from diverse backgrounds.

- Conduct a needs assessment before providing services.
- Take time to actively listen to your patient.
- Use open-ended questions and monitor your patient's facial expressions to gauge his or her reaction to the information you are providing.
- If your patient speaks little or no English and an interpreter is not available, speak slowly and repeat information often and in different ways.
- Question your patient's perception of his or her illness to uncover any hidden agenda, unexpressed fears or cultural taboos.
- Understand potential barriers to, and develop strategies for, overcoming noncompliance with medication and treatment protocols. ■

Separating the Real from the Quackery

Navigating the Information Superhighway isn't always easy, and it can be difficult to glean legitimate information from the glut of material out there. For general, day-to-day use, this confusion is merely irritating; however, when an Internet search involves medical recommendations and guidance, misinformation means danger.

A recent article in Young Physicians tackled the subject of identifying authentic, accurate medical information on the Internet, and separating valuable advice from that which is, as one Internet watchdog put it, "Quackery." Tips included:

- Look for documentation, including authorship (names of authors and their credentials), attribution (references and sources), disclosure (ownership of the site), and currency (date of posting). Medical information on the Net still requires the same documentation as printed information.
- Do not be swayed by the look of the site. Just because a page contains a glossy or showy presentation, users should not assume that the information contained therein is necessarily legitimate.
- Refer to sites that provide recommendations for reviewing medical information on the Net. Many of these sites also offer physician reviews of existing medical sites.
- Look to recognizable health institutions' sites (DHHS, NIH, FDA, etc.) for links to university libraries, medical journals, etc.
- Clinicians should warn patients against purchasing any health products online or taking any medical advice from the Internet without first checking with their physician.
- Check out these helpful sites:

  Quackwatch: ***www.quackwatch.com***

  FDA: ***www.fda.com***

  Physicians' Choice: ***www.mdchoice.com***

  Health on the Net: ***www.hon.ch./*** ■

Length of Service Awards

The NHSC Provider Recognition Program recently chose 18 clinicians, currently in practice in underserved communities, to receive awards based on their years of dedicated service. Awards are presented for 1, 3, 5, 10 and 20+ years of service beyond the commitment to the NHSC. Nominations may be submitted throughout the year by clinicians, site field offices and others. Contact your NHSC field office for more information.

Key to Programs

SCH	=	NHSC Scholarship
SLRP	=	Scholarship and Loan Repayment Program
LRP	=	NHSC Loan Repayment Program
FA	=	Federal Assignee

ONE-YEAR AWARDS

John H. Schneider, Jr., MD	LRP	Sparta, MI
Ann M. Pick, NP	LRP	Sioux City, IA
Sarah B. Morgan, PA-C	SCH	Onawa, IA
Pedro Perez, DDS	LRP	Loving, NM
Kimberly A. Cain, MD	LRP	Onawa, IA
Joseph H. Nadeau, PA-C	SCH	Savannah, MO
Karen Gedney, MD	SCH	Carson City, NV
Mellonese Harrison, MD	SCH	Elko, NV
Earnestine Kearton, RN	FA	Dallas, TX
Carl R. Leviseur, MD	SCH	Pahrump, NV
Curtis A. Mock, MD	SCH	Onawa, IA
Gerard J. Stanley, MD	LRP	Onawa, IA

THREE-YEAR AWARDS

Joseph Koliadko, Jr., DDS	LRP	Red Bluff, CA

FIVE-YEAR AWARDS

Robert Dawson, MD	FA	New Orleans, LA
Ellis Frazier, MD	SCH	Chillicothe, OH

TEN-YEAR AWARDS

Steven Michael Beatty, MD	SCH	Anna, IL

TWENTY-PLUS-YEARS HONORARY AWARDS

James Cody, FNP, PA-C	FA	Wessington Springs, SD
Edmund Trujillo, DDS	FA	El Rito, NM

NHSC Alumna Wins Award

An NHSC alumna has been formally recognized once again for her inspiring dedication to the residents of Bayou LaBatre, AL.

This past April, Regina Benjamin, MD, was named the recipient of the Nelson Mandela Award for Health and Human Rights, and was presented with the award by Archbishop Desmond Tutu, the South African Nobel Peace Laureate, at a ceremony in Key Largo, FL.

The Nelson Mandela Award was established in 1993 by the Henry J. Kaiser Family Foundation and is presented each year to an American and a South African for extraordinary leadership in improving the health of disadvantaged populations in their own countries.

Dr. Benjamin has been doing just that for more than 10 years. As an NHSC scholar, Dr. Benjamin fulfilled her NHSC obligation and remained in Bayou LaBatre, a community on the Gulf Shores of Alabama, where she is dedicated to the practice she established in 1990. At the same time, Dr. Benjamin often extends her efforts beyond her community, and has achieved notoriety and recognition for her work.

Dr. Benjamin served on the American Medical Association Board of Trustees from 1995 through May 1998, becoming the first black female to do so. She was named one of America's 50 Young Leaders by Time Magazine in 1994. And she continues to speak at conferences and serve on various State and national boards in support of health care for the underserved.

As a recipient of the Nelson Mandela Award, Dr. Benjamin was provided the opportunity to nominate a nonprofit organization for a grant of $10,000 from the foundation. She has nominated Mercy Medical, the only in-patient hospice in Alabama, to receive the grant. She also has the opportunity to design a work-study tour of the United States for a period of up to four weeks, and to travel to South Africa within the next couple of years to meet with health care practitioners there.

"I welcome the opportunity to learn more about South Africa and their health care system and contribute in any way that I can in that respect," she says. ■

Upcoming Conference Dates

NHSC Conferences

If you are a scholar, loan repayer or provider and have not yet attended an NHSC conference, or if you are a new awardee, we encourage you to join us for a valuable orientation to the program. Check these dates for an upcoming event near you. When you have determined the conference you would like to attend, call J&E Associates at 800-646-5317 x309, or visit our Web site at www.bphc.hrsa.dhhs.gov/ nhsc/conferences/ to make reservations and arrange for financial support.

Oct 16-18, 1998	Atlanta, GA
Nov 20-22, 1998	Phoenix, AZ
Jan 8-10, 1999	San Jose, CA
Apr. 9-11, 1999	Dallas, TX
Oct 15-17, 1999	Milwaukee, WI
Nov 5-7, 1999	Orlando, FL
Jan 21-23, 2000	Seattle, WA

Other Health Care Conferences

Community-Campus Partnerships for Health (CCPH) is a non-profit organization committed to fostering partnerships between communities and educational institutions that build on each other's strengths to develop their roles as change agents for improving the overall health of communities. Working across sectors of higher education, communities and disciplines, CCPH serves as a bridge between many government and foundation-sponsored initiatives in community-oriented health professions education.

Upcoming CCPH Conferences

Service-Learning Reflection, Assessment and Continuous Improvement: Best Practices in Health Professions Education

Oct. 22-25, 1998 — Denver, CO

Interdisciplinary Service-Learning: Best Practices in Health Professions Education

Dec. 3-6, 1998 — Lexington, KY

1999 National CCPH Conference: Leadership for Healthier Communities and Campuses

Mar. 26-30, 1999 — Seattle, WA

For more information, call Joanna Hunter at 415-502-7933 or visit CCPH's Web site at www.futurehealth.ucsf.edu/ccph.html.

St. Paul Clinic Is Model of Community Service

Once a week, a van from the Model Cities Health Center pulls up to the Skyline Towers complex in St. Paul, MN, a 24-story, 500-unit building that houses about 800 residents and is one of the city's largest public housing projects. The van's occupants are health practitioners arriving for their scheduled visit. They will treat, counsel and check-up on a patient population consisting largely of refugees and immigrants who represent 29 different spoken languages. About half of the residents are on Medicaid and many are uninsured.

"Our services have really made a difference for the residents of Skyline Towers," says Carol Hargate, a pediatric NP and Lead Provider for the Medical Unit of the Model Cities Health Center, an NHSC site. "Communication has definitely been a problem, especially early on. We used a lot of visuals. But we have more translators now."

The Model Cities Health Center staff have been providing health education and treatment services, as well as an annual health fair, to the residents of Skyline Towers for several years. The Model Cities van is just one example of the various programs and community outreach efforts the health center directs.

For St. Paul's large community of Hmong and Laotians that live in housing projects throughout the city, the Model Cities Health Center has sponsored an annual flu shot outreach program, prenatal and diabetes screening, and other programs that provide health information to residents, while at the same time recognizing certain sensitivities such as this population's cultural beliefs and trust in herbal medicines.

"The cultural perspective that the residents of these communities have provided is very important," says Hargate. "Our staff respects the community, and the variety and differences that are out there."

The Model Cities Health Center was originally established in 1967 as part of a larger effort under the Johnson Administration. The health center began as a volunteer clinic operating out of a community center and was affiliated with the city of St. Paul. In 1987, the clinic moved into its own building and began operating through the support of Federal and private grants, as well as third-party providers. The health center currently serves about 250 patients per week, and maintains its own multicultural staff that includes one full-time family practice physician and two nurse practitioners.

"We have gone out of our way to employ people of various cultural backgrounds—Haitian, Hispanic, African American and Southeast Asian—in order to benefit our patients and be as responsive as we

can," says Dorii Gbolo, Director of Clinical Programs.

In 1996, the Center implemented its Infant Car Seat Safety program, distributing approximately 100 car safety seats to low- and moderate-income families in the community with infants and small children. A car seat safety course was also provided by the Center to ensure that the seats were used properly.

Hargate says she has found it particularly rewarding to follow the progress of many of the young patients she has treated since they were born, especially those growing up in adverse family situations who continue to thrive. "It was always in my heart to work with the underserved population. I am particularly interested in culturally diverse populations, especially children, because for them early intervention can really make a difference."

"When people come in to our clinic they feel comfort and stability," she adds. "This is a common starting place in that we are there with them at the initial stage of whatever their health issue may be, and then we see them through it with treatment or counseling." ■

SEARCH Program Launched

The NHSC Student/Resident Experiences And Rotations in Community Health (SEARCH) program was launched on September 1, 1998. SEARCH, formerly known as the Fellowship of Primary Health Care Professionals, received more than 40 applications in response to the announcement of the availability of grant funds. The applications were reviewed and scored by Objective Review Committees, and 23 States were selected to receive FY1998 funds. If additional funds become available, other States may be able to participate in the program. Call 1-800-221-9393 for a list of participating States, points of contact, and phone numbers.

Although the SEARCH program will vary from State to State, its overall objectives are to provide interdisciplinary experiences that will nurture the development of culturally competent, community responsive primary care providers. The needs of the community are assessed and addressed through State partnerships and academic linkages. ■

LOAN Repayment Program

Final year medical residents and graduating health professions students interested in the Loan Repayment Program (LRP) should call 1-800-221-9393 for more information or to request a vacancy list and follow-up with sites where they would like to practice. The applications should be available in late October. ■

Bringing Teens into Your Practice

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Working with Teens

With the stakes so high, clinicians can't afford to shy away from talking with teens every chance they get, says Barbara Malat, a pediatric NP in Rochester, NY. Malat wrote about her work with adolescents in a recent issue of ADVANCE for Nurse Practitioners. Malat admits that sometimes her adolescent patients appear sullen or distant, and may be more difficult to approach than some adults, but she insists that the time is well spent.

"My philosophy revolves around simple concepts: We need to recognize key risk factors (potential life-threatening behaviors) and prioritize them. We need to address them ... and develop a plan to reduce risk. This continuum may involve a few brief follow-up visits ... Change in adolescents is not as concrete as watching numbers or lab values, but seeing teens make positive life-changing behaviors can be very rewarding."

Paul agrees. While Paul now sees patients from all age groups, she specialized in adolescent health in her PA training and while working on her Masters in Public Health. One of the keys in talking with teens, she says, is to relax and give the patient your undivided attention. "No matter how short the visit, I like to get an assessment of how they are doing in school, and give them a chance to talk about whatever they want," Paul says.

Paul's patients have the option of seeing her without their parents, which leads to another key point in adolescent care: confidentiality. Paul makes sure that her patients know the conversations and charts are confidential and won't be revealed to their parents without their knowledge.

Generally speaking, Paul says she has had the most success working with teens when she takes a two-pronged approach. "First, convince them of your friendship and interest in them as people," she says. "And second, convince them that you are someone they can look up to and ask questions—show that you are a medical professional."

Drawing Teens In

The problem isn't just how to talk with adolescent patients who are sitting in your office, but also how to pull them into a clinic setting in the first place. Several clinicians reported that sports physicals are a good way of getting adolescents into the office to start a discussion. For the non-athlete, however, there is always acne.

John Richards Jr., MD, wrote in the Journal of Family Practice about his "Zits for Health" program. He explained that teens, eager to be rid of acne, agree to his conditions for treatment, which include prescription antibiotics and skin cleansing, and five weekly visits where they talk about tobacco, alcohol and other drugs, sex, and other topics.

"It is far less anxiety-provoking for teenagers to tell their parents that they are going to the doctor for their acne than to talk about tobacco, alcohol, drugs, pregnancy or AIDS," he writes. "As part of the last session, I strongly encourage every one of the teenagers to go to their parents for further information and guidance."

As part of its child health program, HRSA funds projects that connect teens and clinicians. Here are a few examples:

Break Down Barriers

South Boston's Project Healthy Asian Teens helps to eliminate language and cultural barriers to health care for Chinese, Cambodian and Vietnamese youth. These youth are targeted because of their high risk for giardia, hepatitis B and tuberculosis, as well as use of tobacco and other drugs, and risky sexual activities. Contact: Jean Lau Chin, EdD, (617) 521-6700 x6711.

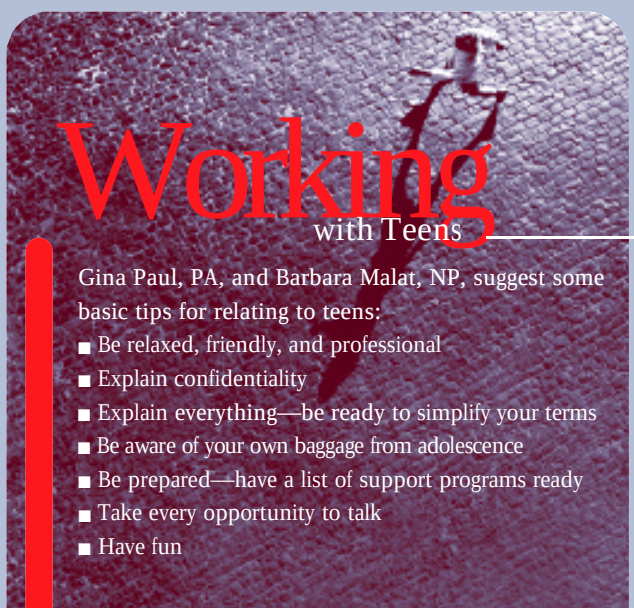
Go to School

The Denver School-based Health Centers Project puts primary health care clinicians, mental health providers and substance abuse services into six Denver-area high schools, one middle school and three elementary schools. By being in the schools, more children are actually using the primary care facilities available to them. Contact: Paul Melinkovich, MD, (303) 436-7433.

Link Teens and Services

Making Dreams Possible for Hispanic Teens, a project in Washington, DC, links Hispanic youths with bilingual community services. The project addresses risky sexual activities and provides basic primary care for teens and their infants. Contact: Elida Vargas, (202) 483-8196.

For more information, visit the HRSA Web site at www.hrsa.dhhs.gov/. ■



Working with Teens

Gina Paul, PA, and Barbara Malat, NP, suggest some basic tips for relating to teens:

- Be relaxed, friendly, and professional
- Explain confidentiality
- Explain everything—be ready to simplify your terms
- Be aware of your own baggage from adolescence
- Be prepared—have a list of support programs ready
- Take every opportunity to talk
- Have fun

Natural Disasters

Continued from page 1

heavy snowfall that was melting with the storms. When water started creeping up on the roads, the towns became islands, accessible only by air. "We were hoping there were no catastrophic emergencies," he says. "There were physicians willing to talk me through procedures, but fortunately that wasn't necessary."

For two weeks, Lang flew between Downieville and Sierra City. After that he drove a four-wheel-drive vehicle, but the trip didn't become easy for several months. As the flood waters receded, Lang and his colleagues decided they needed to learn emergency management. "We created lists of what we need to take to supply basic care and learned the procedures," he says. "We are the only clinic for a long way. If we can't use our x-ray machine or main equipment, we still need to be able to supply care."

Florida Fires

From where Hector Octaviani, MD, works, the Florida fires of 1998 are all smoke. "It's like being in a fog every day," says Octaviani, an NHSC alum and medical director of Central Florida Community Clinic in Sanford, FL His clinic is a few counties away from areas that were evacuated in early July. So far, he says, his area has been lucky, missing most of the problems caused by the fire. "People have been following the advice of staying inside with air conditioning running. And it has started to rain."

Maine Ice Storm

It was a quiet storm, says Max Barus, MD and NHSC alum. In January 1998, Leeds, Maine, had a couple days of mist and then the town woke up to find several inches of ice coating everything. The power was out for 14 days. People cooked on gas stoves, got heat from wood fires and checked in on their neighbors. It was a hardship, Barus admits, but not horrible.

"I saw some people, especially older patients, who were colder than they should have been, a few with [carbon] monoxide poisoning, and a few more slip-and-falls, but generally people tried to cope."

Barus, who is medical director of the Russell Medical Center, helped his site cope by driving to Massachusetts to get a gas-run generator. He then became the "generator doc" in addition to seeing his human patients. On the whole, he says, Leeds residents came through the storm with few scars, but he did notice that rural areas did better than towns. "In rural areas, people still have the gas stoves, and still have wood cut ready to use. They also looked in on their neighbors more."

Midwest Floods

When the Mississippi River overflowed its banks in July 1993, the effect on communities was devastating. Homes, businesses and farms all disappeared underwater. For the Davenport (Iowa) Community Health Clinic, the flooding meant more business. "Basically we were understaffed and stuffed into too small a place," says Rebecca Wiese, MD, medical director of the clinic.

Wiese says there were a few flood-related physical injuries—people bitten by rats while sandbagging—but the mental problems were far worse. "We were seeing people who were stressed out, who were crying because they lost everything. When someone's business goes under it takes a long time to recuperate."

Virgin Island Hurricane

In September 1995, Hurricane Marilyn flattened the Virgin Islands St. Croix and St. Thomas. "It looked like a war zone," says Rick Niska, MD, Chief Medical Officer of the NHSC, who flew in to help.

> "Stepping on nails was the most common injury."

Niska led a disaster medical assistance team that worked on the islands for two weeks. The team set up shop immediately, allowing the local doctors to tend to their own housing problems. "We were extremely busy. There were four doctors working and we still had people standing out the door." The injuries came not from the hurricane itself, but from cleaning up, he says. "Stepping on nails was the most common injury."

His team also provided outreach services, supplying insulin, blood pressure medication and other common prescriptions to patients who were running out. Bringing supplies with you is one of the rules for disaster relief work that Niska has learned. His other recommendations: "Don't go in and become part of the problem—be self-sufficient. And have some mechanism for keeping in touch with your family." ■

Breaking Down Barriers

In February 1997, the Health Resources and Services Administration (HRSA) awarded $1 million to evaluate and improve care for Native Americans living with HIV/AIDS.

The grant was awarded to the Alaska Native HIV/AIDS Case Management Project, the HIV/AIDS Integrated Services Network and the Red Ribbon Bridge Project and is administered by the National Native American AIDS Prevention Center (NNAAPC).

"These projects offer models of HIV/AIDS care that break down the barriers Native Americans face in accessing needed services—medical, mental health, substance abuse, housing legal assistance and other support services—that respect their culture, spiritual needs and traditions," noted Department of Health and Human Services Secretary Donna Shalala when the awards were announced.

The projects were funded under the Special Projects of National Significance (SPNS) Program, as part of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

Paul Bouey, NNAAPC's director of research and evaluation and project director for the HIV/Integrated Services Network, says that the SPNS sites have been working together for the past 18 months to determine how to measure the effectiveness of the services provided to Native American populations. Bouey explains the significance of this grant. "AIDS funding is one of the few resources that Native organizations can access. If you eliminate SPNS money, you eliminate 80 to 90 percent of the HIV/AIDS care funding for Native populations," he says.

The grant is already making a difference, according to Heather Davis, project director for the Chugachmiut, one of the three regional Alaskan Native health providers that received the award.

"The villages we serve are accessible only by plane or boat," Davis points out. The grant is helping us reach those HIV-positive individuals who want to remain at home.

For more information on HIV/AIDS care for Native populations, visit the NNAAPC Web site at www.nnaapc.org.

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